DRVD
CONFIDENTIAL REPORT

AN INVESTIGATION INTO AN APPARENT SUICIDE

Thirty- one year-old, male resident of Western State Hospital, died from an apparent suicide.

DRVD CASE# 96-0366M
Department For Rights of Virginians With Disabilities
Fishersville Field Office
Beth Chadwell, Advocate
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I. INTRODUCTION

This report summarizes the findings of my investigation into the death of WM, a 31 year-old, deaf, Caucasian male, who was a resident at Western State Hospital ("WSH"), a state mental health facility, in Staunton, Virginia. WM was found dead in a male bathroom on his ward at WSH from an apparent suicide at approximately 6:30 p.m. on May 4, 1996.

I conducted this investigation pursuant to the Protection and Advocacy for Mentally Ill Individuals Act of 1986. My investigation included the following:

1. Review of WM's medical records at WSH;
2. Review of WM's medical records from Riverside Regional Medical Center ("RRMC");
3. Interview with WSH's Risk Manager regarding the death of WM;
4. Review of the Virginia State Police Investigative Report regarding the death of WM;
5. Review of Virginia Medical Examiner's Report regarding the death of WM; and
6. Review of WSH's Security Report regarding the death of WM.

II. BACKGROUND

WM was a 31 year-old, mildly mentally retarded, deaf, Caucasian male, with a history of Dysthymic Disorder. He was admitted to RRMC, a private general hospital in Newport News, Virginia, on April 27, 1996 due to a suicide attempt in which he cut his forearms with a razor.

Upon admission to RRMC, WM told staff that he was hearing voices, which were telling him to jump off a bridge. He told staff he was not happy and wanted to give up because he did not feel necessary in life. RRMC diagnosed WM with Psychotic Disorder, Mild Mental Retardation, and Deafness.

After five days of inpatient hospitalization at RRMC, WM's functioning was considered to be satisfactory by staff, although they believed he was at risk of immediate decompensation after discharge based on his history. WM's history indicated that he would typically become suicidal in the context of interpersonal stress and/or drug abuse and/or legal charges. He would then complain of hearing voices and seeing things, which would result in his hospitalization.

WM was transferred to WSH on May 3,1996 due to the risk of re-hospitalization and his refusal to return to the group home where he was living prior to admission to RRMC. WM had 16 previous admissions to WSH, the most recent from January 5, 1996 to February 14, 1996. According to WSH records, WM's most recent diagnosis was:

1. Axis I: Dysthymic Disorder 300.4; Alcohol Abuse 305.; Cannibis Abuse 305.20.
2. Axis II: Borderline Personality Disorder 301.83.
3. Mild Mental Retardation 317.
4. Axis III: Hard of Hearing

Records indicated that at the time of WM's admission to WSH on May 3, 1996, he was being treated with the following medications, originally prescribed for him by RRMC:

1. Divalproex Sodium (Depakote-mood stabilizer) 250mg.qam, 500qhs
2. Risperidone (Antipsychotic) 3 mg. bid
3. Sertraline (Depression) 50 mg. am

WM's WSH medication record reflected he was being treated with the following medications at the time of his death:

1. Valproic Acid (Depakote - mood stabilizer) 250 mg.qam, 500qhs
2. Buspar (Anxiety/Depression) 5 mg. bid
3. Thiothixene (Agitation/Anxiety) 5 mg. q4hrs PRN

WM's WSH record indicated that he was taken off of Risperidone upon admission to WSH due to his history of side effects with this medication such as dizziness and nervousness. WM's WSH physician prescribed Buspar as an alternative, which in the past had helped with his depressive symptoms with the least amount

of side effects. Upon admission to WSH, WM told nursing staff that his medications had been changed at RRMC from what his previous regimen had been at WSH. He told staff he believed this might have made him confused.

III. CIRCUMSTANCES SURROUNDING THE DEATH OF WM

A. Care Provided to WM at WSH

Upon admission to WSH on May 3, 1996, WM described himself as being depressed and spoke of continued suicidal ideation. He told the admission office staff that he would not commit suicide in the hospital, but if he did feel suicidal he would tell staff. After a nursing assessment and physical examination, WM was placed on 15-minute checks at 1:45 p.m., in compliance with Hospital Instruction Number 4011, pertaining to his suicidal ideation. He was then escorted to Ward D7/8, the Mental Health Center for the Deaf.

At 3:30 p.m., WM was noted by staff to be pacing in the dayroom. Later in the evening he was noted by staff to be restless. The WSH record did not disclose that he made any suicidal threats or gestures to harm himself.

B. May 4, 1996 Sequence of Events

The WSH record indicated that, on May 4, 1996 at 6:30 a.m., WM had slept through the night on a cot in the dayroom with no suicidal gestures or ideations. At 8:15 a.m., WM took his medications, denied hallucinations, and contracted with nursing staff not to hurt himself.

At 2:00 p.m., in compliance with a May 3, 1996 physician's order to reassess WM after 24 hours, the Licensed Practical Nurse telephoned the WSH physician on call. She told him that WM was not experiencing any suicidal ideation and was capable of contracting not to harm himself. Based on this information the WSH physician on call verbally changed WM's 15-minute checks to 1-hour checks, with continued sleeping on a cot in the dayroom.

At 3:30 p.m., WM complained to nursing staff that he was upset and he requested his PRN medication, Thiothixene, to alleviate his discomfort. He was given his PRN and was observed by nursing staff at 4:45 p.m. to be calmer as a result of the medication intervention. WM was checked at 6:00 p.m. and was found to be in the dayroom lying on his cot. At 6:15 p.m. WM approached the ward nursing office, where several staff persons were

eating their dinner, and reportedly looked in the door without saying anything. He then turned around and left.

The Registered Nurse wrote in the record that at 6:25 p.m. another deaf resident on the ward ran down the hall making "panicky" noises, and appeared to be upset and frightened. As a result, she and the Human Services Care Specialist ran down the hall with the resident to the men's bathroom, where he pointed to the handicapped bathroom. When the Registered Nurse and the Human Services Care Specialist opened the door, WM was hanging by a red cord from the door brace with the cord doubled around his neck. The Registered Nurse and the Human Services Care Specialist attempted to take WM down, but his weight coupled with the cord made it difficult. While WM's weight was held up by the Registered Nurse the Human Services Care Specialist loosened one loop from around WM's neck and removed the cord.

WM was unresponsive when taken down and CPR was started at 6:30 p.m. The WSH Information Center was called at 6:32 p.m. to get emergency services to the ward immediately. WSH security, the WSH physician on call, and another WSH physician, arrived on the ward at 6:45 p.m. The Staunton/Augusta Rescue Squad arrived on the ward at 6:48 p.m. and continued resuscitation efforts. At 6:55 p.m., the WSH physician on call stopped CPR and pronounced WM dead. No suicide note was found.

The Human Services Care Specialist, in her interview with the Virginia State Police, said that she last saw WM on May 4, 1996 at 6:15 p.m. She said she was eating her dinner in the nursing office with other staff when she observed WM at the open door of the nursing office. When WM saw that staff were eating, he turned and walked away.

After she ate her dinner, she was standing in the hallway when another deaf resident on the ward walked toward her making the deaf sign for "hang" and pointed at the bathroom. She said that she and the Registered Nurse went into the bathroom and opened a stall door and found WM hanging with a cord wrapped around his neck. She said she and the Registered Nurse managed to lift WM up so that the cord could be unwrapped from around his neck. She stated that after continuous resuscitation efforts no pulse could be found, so CPR was stopped.

C. Other Investigations

The Augusta County Medical Examiner did not request an autopsy based on WM's history of suicide attempts. According to the Augusta County

Medical Examiner's opinion, WM took a chair from the bathroom used to seat patients who are unable to stand while being shaved, and placed it in the bathroom stall. WM then removed the red shoelaces from his shoes, which were each 60 inches in length and tied one around the support bar. The Augusta County Medical Examiner said it appeared that WM stood on the chair, wrapped the shoelace around his neck two times, and then jumped off the chair.

The Virginia State Police investigated WM's death. Their investigation found no basis for a finding of criminal activity in the death of WM.

IV. FINDINGS AND CONCLUSIONS

This investigation revealed that: (i) WSH failed to follow the procedures outlined in Hospital Instruction Number 4010 - Suicide Prevention, and (ii) Hospital Instruction Number 4011- Special Observation and Monitoring of Patients.

WSH failed to comply with the requirements of Hospital Instruction Number 4010, *Suicide Prevention*, which is dated August 5, 1994. That policy requires that:

> Every attempt should be made to prevent patients on suicide precautions from having access to sharp objects, to any type of cord, necktie, bath robe sash, etc. which might be used in hanging, and matches, lighters, or any other objects that the patient might use to inflict self-injury.

WM had been assessed by a physician, upon admission to WSH, to be actively suicidal. There was no documentation in WSH's record that WM had been searched for dangerous items, such as his 60-inch shoelaces, at any time during his hospitalization.

WSH also failed to comply with the requirements of Hospital Instruction 4011, *Special Observation and Monitoring of Patients*, which is dated September 1, 1988. That policy requires:

> The order for discontinuing or decreasing the level of special observation (i.e. changing from one-to-one observation or direct observation to 15-minute checks) must be based on the physician's personal assessment of the situation, and documentation must address why the previous level of special observation is no longer required.

The WSH record documented that WM's 15-minute checks were decreased to one hour on the basis of the telephone call from a nurse to the physician on call, who changed the order without seeing WM. The WSH Physician's Progress notes, Interdisciplinary notes, and the Physician's Order Form document that the WSH physician on call decreased WM's checks from 15 minutes to one hour without observing WM. No personal assessment of WM by a physician occurred, in direct contravention of WSH's own policy.

V. RECOMMENDATIONS

The following recommendations are suggested based upon the above findings and conclusions:

1. WSH should revise Hospital Instruction Number 4010. The policy specifically needs to identify the staff person(s) responsible for ensuring that all dangerous objects are removed from patients on suicidal precautions, specify when a search for dangerous objects must occur, and how frequently the search will be repeated.

2. WSH should ensure that Hospital Instruction Number 4010 and 4011 are followed by WSH staff persons. WSH should require all physicians, nurses, and direct care staff to attend yearly training on policies relating to suicide prevention and special observation and monitoring. WSH should also require new employees to receive training, during employee orientation, on policies related to suicide prevention and special observation and monitoring.